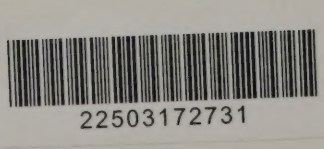
NHS reforms

The first six months

NHS Management Executive



NHS reforms

The first six months

Contents

Foreword

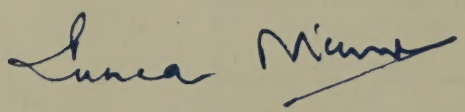
This report provides an assessment of the performance of the NHS in the half-year between April and September 1991. This has been a period of immense change and new challenges for the health service. The NHS reforms have come into effect and changed the way the entire NHS now operates. I hope that this report will help to keep you fully informed of the progress that has been made across the service.

Changes in the way the NHS is organised have helped to re-focus our activities. They are leading to improvements in the quality of care, greater responsiveness to individuals and even better value for money from the growing NHS budget. I particularly welcome the progress made in the following areas:

- figures for the first six months of 1991/2 indicate that an extra 250,000 patients will be treated this year (up 3.7 per cent on last year). This includes an increase of 170,000 in the number of day cases (up over 13 per cent);
- the number of patients waiting over two years for treatment has fallen by 8,000 in the first six months of the year (down 16 per cent);
- primary care services are continuing to improve, for example the latest available figures show record levels of childhood immunisation coverage with around 90 per cent of children immunised against diphtheria, tetanus and polio, whooping cough and measles;
- within this overall level of performance, there has been a vast range of local initiatives to improve the care provided to patients which demonstrate the real impact of the reforms on individuals.

I would like to thank all NHS staff for their contribution to such an encouraging start for the reformed NHS. However, it is only a start and much more remains to be done. Despite substantial reductions, people are still asked to wait too long for treatment; we need to improve even further the quality of services available; the development of community and primary care services needs to continue, and we cannot yet claim that we make the most effective use possible of the vast resources available to us. All these challenges will be resolved not just by the efforts of those who work within the NHS, but also by listening and responding to those we serve.

The report cannot acknowledge all the many examples of good practice and progress. However, I hope it will act as a stimulus to further change and improvement, and to the continued search for excellence in delivering health care. We all need to build on what has been achieved so far to ensure that standards throughout the NHS continue to improve.



DUNCAN NICHOL
Chief Executive

Introduction

1 April 1991 saw the implementation of the NHS reforms throughout the health service. These have involved fundamental changes in the management and funding arrangements of the service. It is worth restating the main objectives of the changes, which centre around separating the role of District Health Authorities (DHAs) from that of hospitals and other units:

- DHAs and Family Health Services Authorities (FHSAs) have taken on explicit responsibility for identifying the health needs of local people and securing health care to meet them;

- NHS contracts between DHAs and hospitals and other units have been agreed, specifying the level, quality and cost of patient services. This ensures that money goes to the units who do the work and tackles the "efficiency trap" of the old system;

- GPs have greater ability to act on behalf of their patients, with volunteer practices able to become GP fundholders purchasing certain hospital services directly;

- hospitals and other units have more control over their own affairs. The logical development of this is NHS Trust status where units can choose to run their own affairs independent of DHA controls but accountable to the NHS Management Executive;

- primary and secondary care is better integrated with both DHAs and FHSAs accountable to Regional Health Authorities (RHAs) for the first time. This is leading to a better balance between prevention and treatment with the increased focus on health needs, not historic service patterns, and on health improvements, not sickness.

The implementation of the reforms, with greater clarity of roles and responsibilities and the emphasis on devolving decision-making as close to the patient as possible, is affecting the entire performance of the NHS.

Overall performance of the NHS

Activity

Acute sector activity

The total number of patients treated in the acute sector (including geriatrics) in the first six months of this year, and the forecast for total activity in the year, show a significant increase over total activity in 1990/1.

	1991-92 first 6 months	1991-92 full year forecast	Comparison with 1990-91 total	
Inpatients	2.9 million	5.8 million	+ 80,000	+ 1.5%
Day cases	0.7 million	1.4 million	+ 170,000	+13.6%
Total number of patients treated (those using a bed)	3.7 million	7.2 million	+250,000	+ 3.7%
Outpatients	16.4 million	32.9 million	+1.3 million	+ 4.2%

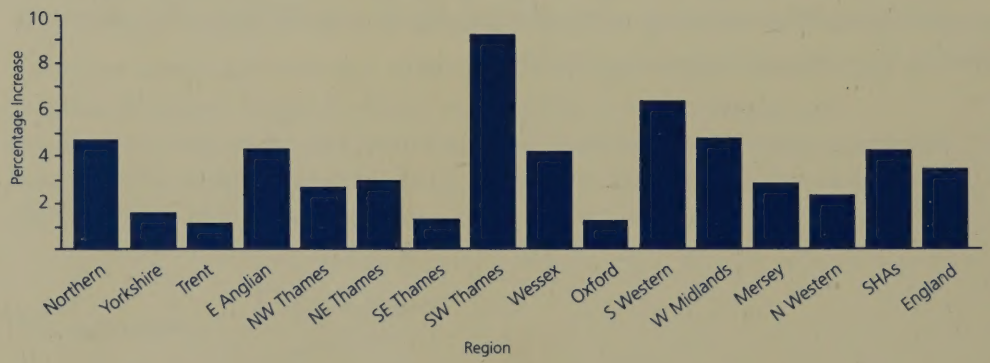
Note: activity figures are provisional.

The figures show an overall increase in forecast activity of 3.7 per cent across the country as a whole. However, there are significant regional variations [*see Graph A*].

Within the acute sector, it is worth looking at progress in a number of priority areas – day cases, specific treatments where more operations were targeted, and action to reduce waiting times.

Graph A

Acute sector activity forecast changes over 1990-91 by region



Notes:
1. 1991-92 figures include Trusts' activity.
2. Figures for 1990-91 exclude activity on contractual sites.
3. Acute sector now includes geriatrics.

Day cases

Increasing the number of patients treated without the need for an overnight hospital stay is important in delivering more appropriate patient care and better use of resources. In the first six months of the reforms over 700,000 patients were treated as day cases – 20 per cent of total activity compared with 18 per cent in 1990/1. There is, however, a significant regional variation in the proportion of patients who are treated as day cases, and varying progress in increasing this proportion. This shows that there is clear room for certain regions to improve performance [*see Graph B*].

Specific treatments

The latest indications from regions indicate good progress in increasing the number of heart by-pass, cataract and hip replacement operations. The best available figures indicate the following:

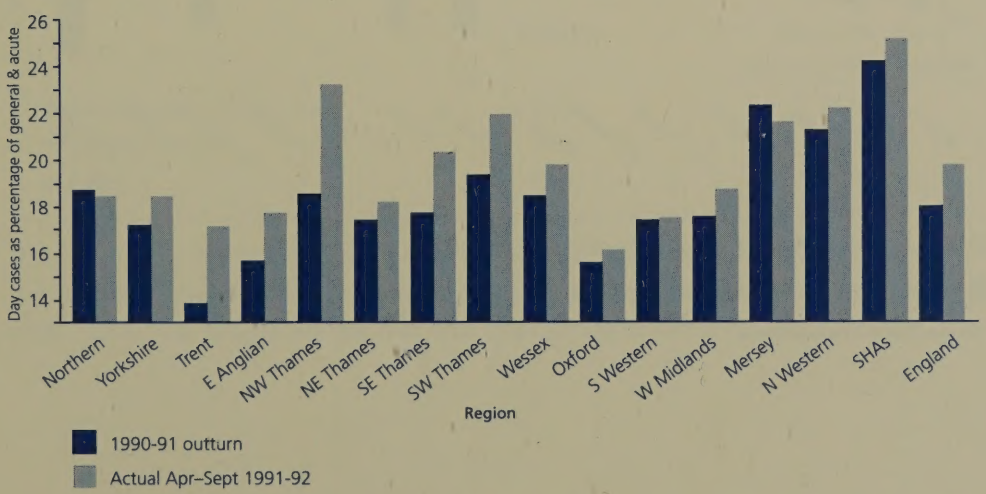
	1991-92 first 6 months[2]	Compared with the same period in 1990-91[2]
Heart by-pass operations	4,510	+ 5.9%
Cataract operations	37,200	+ 5.5%
Hip replacement operations	20,430	+ 7.6%

[2] Provisional figures from 12 regions; two regions did not have comparable data.

Waiting times

	September 1991[3]	Change from March 1991		Change from September 1987	
Inpatients and day cases waiting over 1 year	159,000	– 11,000	– 7%	– 50,000	– 24%
Inpatients and day cases waiting over 2 years	43,000	– 8,000	– 16%	– 47,000	– 52%

[3] Provisional fast-track waiting list figures.



Graph B

Acute sector activity – day cases as a percentage of total 1990-91 and first half of 1991-92

Notes:
1. 1991-92 figures include Trusts' activity.
2. Figures for 1990-91 exclude activity on contractual sites.
3. Acute sector now includes geriatrics.

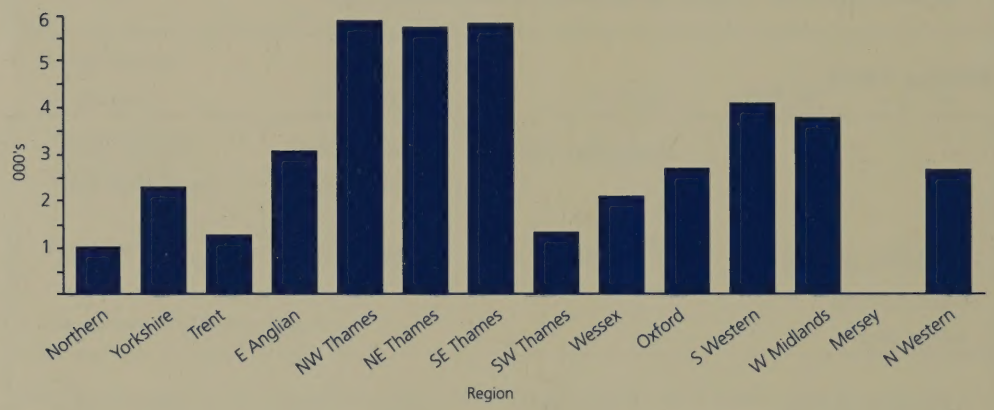
The waiting times figures indicate continued progress in tackling this problem since the start of the waiting time initiative in 1987. The reduction in the number of patients waiting a long time for treatment since April needs to be taken further in the second half of the year. Graph C shows the number of patients waiting over two years for treatment in each region at the end of September 1991, and Graph D shows how progress in reducing the numbers waiting over one and two years has varied from region to region so far this year.

100 extra consultants

Progress in tackling waiting times was speeded by the funding of a further 100 consultant posts as part of the NHS reforms. The new posts were specifically targeted at those specialties with particularly long waiting lists – notably in acute services. All 100 posts are now filled and centrally funded at an average cost of £420,000. A survey of the effect of the first 65 posts on waiting lists shows that significant reductions in the number of those waiting over one year have been achieved, for example a reduction of some two-thirds of the trauma and orthopaedics waiting list at Preston (over 430 patients). The 100 extra consultants initiative was part of an overall increase of over 1,800 consultants in the five years to September 1990 – an increase of over 12 per cent in consultant numbers during that period.

Graph C

Number of patients waiting over two years by region at September 1991

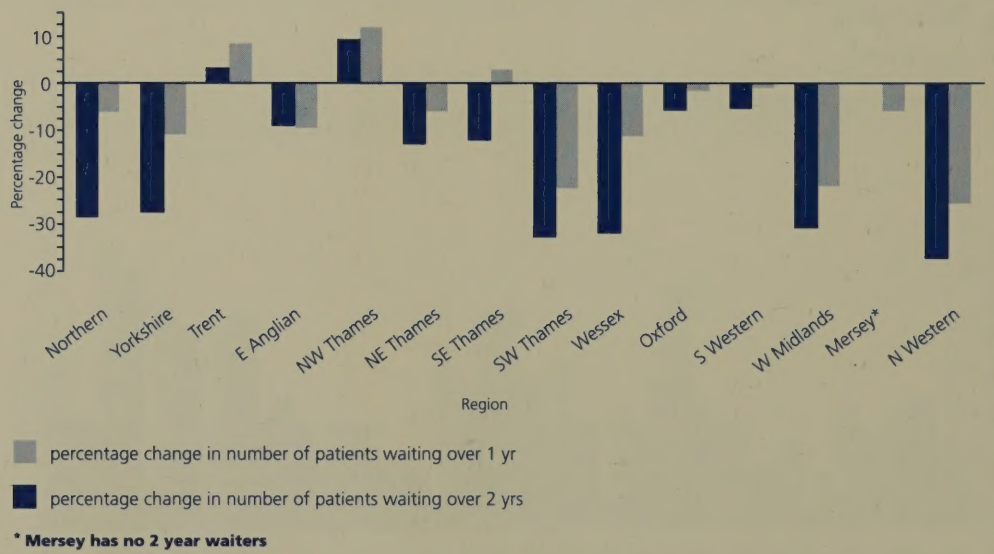


Graph D

Change in number of long wait patients

Percentage change by region (inpatients and day cases)

First six months of 1991-92 (to Sept)



*** Mersey has no 2 year waiters**

Patient's Charter waiting time guarantees
One of the central aims of the Charter is to ensure that people no longer have to wait a long time for their operations and that they will know well in advance when they can expect to be admitted to hospital.

The *Patient's Charter* introduces a new right on the waiting time for treatment. This right guarantees admission by a specific date no later than two years from the date when the consultant places the patient on a waiting list. It is important to emphasise that few patients will have to wait as long as the maximum two years. In fact, half of all admissions from waiting lists are within five weeks, and 80 per cent within six months.

Primary care activity – GPs
The White Paper *Promoting Better Health* set out a range of initiatives to improve primary care. One of the main elements of the implementation of the proposals is the new GP contract. Doctors and their practice staff have responded positively to the challenges and opportunities of the new contract and now offer a wider range of health care than ever before.

The figures for the first year of the new GP contract (1990/1) indicate that it had a major impact:

- almost 90 per cent of GPs received target payments for hitting ambitious targets for cervical screening and childhood immunisation (with almost 70 per cent receiving higher target payments);

- over 170,000 minor surgery sessions were held by GPs providing some 850,000 individual operations;

- almost one million health promotion clinics were held in the year.

All the signs are that there will be further improvements in 1991/2. The latest figures for childhood immunisation coverage (where GPs and community and practice nurses play a major role) confirm this:

	Coverage of the population	
	1989-90	Provisional figures for year to September 1991
Diphtheria, tetanus and polio	86%	92%
Whooping cough	75%	87%
Measles	80%	90%

The latest figures for notifications of illness indicate that whooping cough, measles, mumps and rubella, and rubella in pregnant women are all at the **lowest levels ever**. In the UK in 1990 for the first time ever no child died from acute measles.

These improvements in care have been backed up by a very substantial increase in the amount of public money invested in GP practice staff and premises' improvements. There has been a rapid increase over recent years in the total number of practice staff employed by GPs, and particularly of practice nurses. Total figures for expenditure on practice staff and premises' improvements and the number of practices which are now computerised are shown below.

	1991-92	1990-91	1989-90
Total expenditure	£564 million (forecast)	£444 million	£315 million
Real terms increase since 1989-90	+50%	+ 31%	–
Number of practices with computers	7,300 (forecast)	6,130	4,610
Practices computerised	75%	63%	47%

Patients' views of GP services

The impact of all these changes is illustrated by recent research on patient perceptions of the GP service. A recent MORI survey indicated that the GP contract has improved services and that patients are reaping the benefits:

- nine out of ten patients who have had recent contact with their GP are satisfied with the services they receive;

- nearly one in three patients have noticed an improvement since the GP contract was introduced.

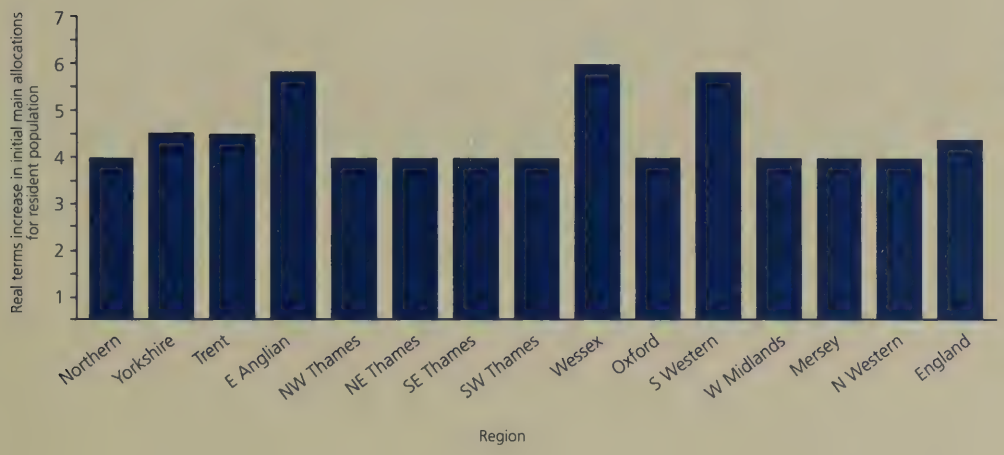
Primary care activity – dentists

Dental health in this country is continuing to improve. The 1988 *Adult Dental Health Survey* (the latest available data) showed a significant increase in the proportion of people retaining some of their natural teeth – up from 72 per cent in 1978 to 80 per cent in 1988. The new dental contract introduced in October last year provides for the first time all-round continuing care. The contract promotes prevention of disease, and offers a full range of dental care. Over 21 million people in England have registered with a dentist under the new contract, a faster take-up than expected.

Finance

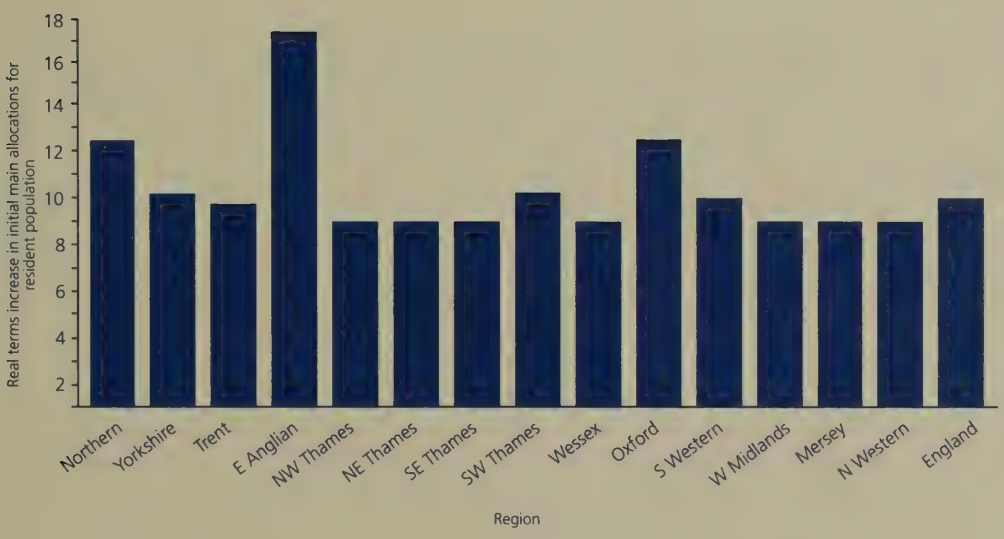
1991/2 resources

Graphs E and F show the real terms increase in regions' initial main revenue and capital allocations for 1991/2. The differential revenue allocations represent a further step in achieving fairer funding based on resident populations.



Graph E

1991-92 Regional allocations – revenue



Graph F

1991-92 Regional allocations – capital

Financial management

The latest information from health authorities and NHS Trusts shows that in general the financial implications of the reforms are being well managed. Performance is broadly in line with plan.

The main points to highlight six months into the year are:

District health authorities

- the action taken last year to restore a balanced income and expenditure position provided a firm base for the reforms. In securing health care for their residents, DHAs are now forecasting a small underlying surplus for 1991/2 which is being used to contribute towards the reduction of waiting lists;

- expenditure on referrals not covered by contracts in advance (extra-contractual referrals) is running in line with plan. In the first half of the year just under 50 per cent of the provision was required and DHAs are forecasting that reserves will be sufficient to cover the likely level of referrals in the second half of the year.

Hospitals and other units

- both hospitals and other units under the control of DHAs and NHS Trusts are forecasting a broadly balanced position for the year;

- directly-managed units and NHS Trusts are continuing to find new ways of providing services more efficiently. Cash-releasing efficiency savings are now forecast at a rate equivalent to 1.3 per cent of expenditure. Savings of £83 million have been made in the first half of the year.

Capital

- a balanced capital position is forecast for the year;

- authorities have adjusted their programmes to take into account the continuing slump in the land sales market. Examples of major building projects started in the last six months include the second phase of Hope Hospital, Salford; South Sefton's accident and emergency (A&E) department; and the development of Frimley District General Hospital;

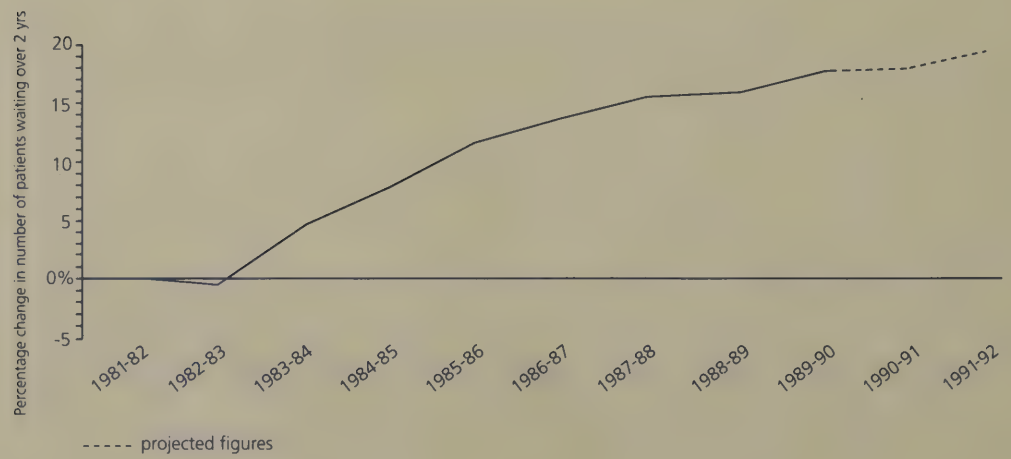
- the capital loans fund has introduced a total of £57 million new money committed to the modernisation of mental health facilities over the last two years.

Better value for money

- overall, in the period 1981/2 to 1989/90, efficiency savings in the hospital and community health service have amounted to around 18 per cent – an average increase of over two per cent a year [*see Graph G*];

- with the reforms, many places are developing improved information on the costs of treatment. The great majority of patient activity is covered by contracts with DHAs and the prices are set mostly on the basis of broad average specialty costs. Next year's pricing is expected to reflect the cost of different activities more closely. This information is not confidential and one of the benefits of the NHS reforms will be the impetus to identify and compare the costs of the services provided so that action can be taken to improve value for money still further.

Graph G
Cumulative efficiency savings in the hospital and community health service since 1981-82 (per cent)



Progress with specific initiatives

Securing health improvements

The role of DHAs and FHSAs in preventing ill health and securing health care for their residents is at the centre of the reforms. The new clarity of their responsibilities has led to a number of encouraging developments. These include a stronger focus on service quality and a greater emphasis on taking account of local people's views. It has also led to greater working together between those responsible for all aspects of health and social care [*see* Working Together, *page 16*].

Quality in contracts

The introduction of contracts for services has stimulated a new focus on the quality of care patients are receiving.

Setting specific quality standards has been a central feature of 1991/2 service contracts and covers various aspects of provision. For example:

- Worcester DHA's contracts stipulate that 90 per cent of patients and clients attending health centres and community clinics are seen within 10 minutes of their appointment time and 100 per cent are seen within 20 minutes;

- Northumberland DHA's contracts require that all expectant mothers are told the name of the consultant responsible for their care and also the name of the doctor who sees them if this is not the consultant;

- Riverside DHA's contracts state that a patient's appointment should not be cancelled more than once unless there are exceptional circumstances.

The NHS will need to agree improved quality standards for 1992/3, in particular to ensure that national and local *Patient's Charter* standards are implemented throughout the country.

Views of local people

Much good work is being done by DHAs to take account of local people's views in assessing local health needs and setting service priorities. FHSAs are also playing their part in this. The NHS Management Executive has issued a paper, *Local voices: the views of local people in purchasing for health,* which suggests ways for health authorities to involve local people in the process of securing health improvements and to promote an informed debate about local health services and issues affecting people's health. Current initiatives include:

- in Derbyshire discussions with groups of local people have been organised by North Derbyshire DHA to explore public perceptions on a range of health issues,

identify priorities and test patient satisfaction; meanwhile Derbyshire FHSA has set up a consumer forum involving voluntary organisations, community health councils and other patient groups to obtain their views on family health services;

- a patient attitude survey of 6,000 patients recently discharged from hospital in East Sussex. New service improvement targets are being included in contracts to follow up concerns identified by the survey;

- Rotherham and Oldham FHSAs have set up "health shops" in the town centres to enable local people to find out about the services available more easily and to pass on their views;

- West Dorset DHA has set up a community initiative based on different localities in the district. The aim is to seek views from each locality through discussions with groups of people drawn from local voluntary organisations, statutory agencies, schools, local residents etcetera, and to develop an action plan with these people to improve health locally;

- Leicestershire FHSA surveyed 1,000 patients from one practice to ask them about access, accommodation and general convenience. The results are being fed back to the GPs. The FHSA intends to use this type of survey more widely.

Ethnic minority health

Taking account of the views of local people should involve all sectors of the population. The NHS Management Executive is committed to promoting equality of opportunity for ethnic minorities in the delivery of health services. This involves positive action to take account of differences in language and culture. The NHS reforms make clear each DHA's and FHSA's responsibility to obtain appropriate health care for all its population including ethnic minorities. Examples of steps being taken include the provision of interpreting services to facilitate communication, the appointment of link workers to overcome barriers of language and culture between patients and health service professionals and the publication of health promotion materials and information about services in ethnic minority languages.

GP fundholders

The fundholding scheme allows those GPs who want to do so to take control of their own fund to secure a defined range of hospital services for their patients and to cover prescribing expenditure and part of the costs of practice staff.

The first wave of GP fundholders started on 1 April 1991, and consists of 1,720 GPs in 306 practices. Around 7.5 per cent of the population (3.5 million people) are registered with these GPs. A similar number of GPs have expressed interest in joining the scheme in April 1992.

There are already many examples of real improvements secured by GP fundholders in making use of their greater control over the resources involved. These benefits are often not just for the fundholder's patients, but can lead to improvements for all patients using that hospital.

Examples of the benefits secured include:

- GP fundholders pressed the John Radcliffe Hospital in Oxford to incorporate a "Patient's Charter" into their contracts for outpatient services. Their Patient's Charter now features in the contracts that the outpatient department has with all purchasers. Quality standards include the requirement that all patients are seen within 30 minutes of their appointment time in clinics;

- a fundholder in South East Thames has moved referrals from the local provider unit to a neighbouring unit. For orthopaedics there was previously a two-year waiting time, now his patients have a three-month waiting time;

- a fundholder in Oxford region has reached agreement with the ophthalmology department to do extra cases and the money will be used to buy an up-to-date piece of equipment which will increase patient throughput. This has already started to lower waiting lists for all patients;

- a fundholder in Lancashire wanted better response times from local pathology laboratories – their negotiations resulted in an improved transport system at the lab, which benefits all practices in the area;

- many fundholders are contracting with consultants to visit the practice and do outpatient sessions, or physiotherapists to provide physiotherapy in the surgery;

- fundholders have been prompted to examine past treatment notes and a GP in Oxford noted considerable duplication of x-rays between GP and hospital – seven per cent in back-pain, 18 per cent in physiotherapy. This has now been eliminated;

- a fundholder in Berkshire has given the local hospital £25,000 to treat an extra 25 orthopaedic patients. The hospital is using the money to build a day bed unit; this will help all patients in the area.

NHS Trusts

NHS Trust status allows hospitals and other units greater control over their own affairs so that decisions are taken by local managers and professional staff best placed to respond to local circumstances. The first wave of NHS Trusts became fully operational on 1 April 1991, and consists of 57 hospitals and other units. Recently the Secretary of State announced that 99 hospitals and other units will be established in the second wave of NHS Trusts in April 1992, while four London teaching hospitals will become operational as Trusts in April 1993.

To date 153 hospitals and other units have indicated that they may apply to become Trusts in April 1993. If all these were to be successful, two-thirds of NHS hospitals and other units would be operating as NHS Trusts.

First-wave NHS Trusts across the country have already made improvements in the care they can offer their patients. Described below are examples of the achievements in some of the 57 first-wave Trusts.

- Southend Health Care NHS Trust is achieving record activity levels. By November it had treated 2,500 more patients than at the same time last year. This represents a six per cent increase on activity overall, which is being achieved within budget. The Trust has completely refurbished its A&E department, making it a more comfortable and welcoming place for patients. Consultants at the Trust visit GP surgeries to provide outpatient clinics and GPs are now able to use Trust facilities for clinics in the evenings and at weekends;

- Northumbria Ambulance Services NHS Trust has improved its response rates well beyond official targets. Ninety-eight per cent of emergency calls are now answered within 14 minutes;

- the United Bristol Healthcare NHS Trust treated five per cent more patients in the period April to September than in the same period last year. All inpatients now have the opportunity to visit an anaesthetic room and talk to staff before they come to the Bristol Royal Infirmary for surgery. The Trust has a free courtesy bus linking the city centre hospitals with car parks and the bus station. It is becoming increasingly popular with patients. The Trust has appointed a new consultant ophthalmology surgeon, whose brief is specifically to treat patients who have been waiting a long time. For general surgery and for urology, the Trust is now holding sessions on Saturdays to treat 300 patients as day cases;

- the West Dorset Community Health NHS Trust has introduced a 24-hour community nursing service. The Trust has also opened a number of new services – in Sherborne there is now a day hospital for the elderly, while in Blandford there is a new day hospital for the young chronically disabled and a new terminal care unit;

- the Freeman Group of Hospitals NHS Trust, Newcastle has installed and commissioned a new CT scanner. They have been bidding for this for seven years, and the regional capital programme did not plan to provide it this century. The Trust has introduced lithotripsy to treat kidney stones. This has eliminated the waiting lists for surgery on this condition throughout Northern region;

- the Royal Free Hospital NHS Trust has made major steps in tackling its waiting lists. In June, it had 560 patients waiting for more than a year for general surgery; in November this was down to 13. The waiting list for non-urgent orthopaedic surgery, for such things as hip joints, has come down considerably. In June there were 440 people on the list who had been waiting for more than a year. By November, that had come down to 200. The Trust has reduced the waiting time for appointments for non-urgent orthopaedic cases from 25 to 15 weeks. The Trust has launched a *Learning from Patients* initiative. This involves interviewing patients and using the local press to ask local people for their comments and suggestions on the Trust's services. The Trust has opened a 100-bed hospital for the elderly – Queen Mary's – funded in part through savings made possible by new efficiencies;

- Broadgreen Hospital NHS Trust, Liverpool has opened a new £4.5 million psychiatric unit for acute and elderly care for mentally ill people. This has moved care into the local community away from a distant institution. The Trust has established a courtesy car service for frail elderly people who have no other means of getting home.

Medical and clinical audit

A systematic programme of medical audit was set in train by the NHS reforms to improve and maintain standards in clinical practice. For 1991/2, £41 million was allocated to regions (on top of £24 million last year) to get the organisational framework for medical audit in place. Patients and populations will benefit from more patient-centred audit of all elements of care. Early examples of work in hand includes activity in Wandsworth to link health gain, contracts and medical audit in relation to prostatectomies and laparascopic procedures.

There are also a number of nursing initiatives in train, in particular standard setting and organisational audit of nursing services. The therapy professions, too, are developing initiatives. Indeed, audit should be seen as an integral part of the work of everyone involved in health care delivery.

The indicative prescribing scheme

The indicative prescribing scheme came into effect on 1 April 1991. It aims to encourage all GPs to improve the quality and effectiveness of prescribing. The scheme is supported by a number of educational initiatives to help get the most out of the £2 billion-a-year drugs bill. The scheme has built-in safeguards to take account of patients who are old or need expensive medicine, and there is no question of vital medicines being withheld. The data available after six months indicate that the indicative prescribing scheme is working well.

Integration of primary and secondary care

The NHS reforms made RHAs responsible for family health services as well as hospital and community health services, so that the NHS has for the first time the management structure to make the integrated planning and purchasing of all health care a reality. RHAs are now able to take an overview of the provision of *total* health care and ensure DHAs and FHSAs work together in securing high quality seamless care for patients to meet local health needs.

Examples of the ways in which integration is achieving improved services for patients include:

- in many places GPs and hospital clinicians are agreeing protocols to enable services previously only provided in hospital (such as the management of diabetes, asthma and psychiatric care) to be transferred to the community;

- the elimination in many places of unnecessary journeys to outpatient departments and unnecessary duplication of diagnostic tests that too many patients experience; and hospital discharge arrangements being improved;

- more joint working between DHAs and FHSAs. For example DHAs and FHSAs in both Doncaster and Bromley have made joint general manager appointments; Cambridgeshire FHSA and the three local DHAs have established joint purchasing boards.

Working together on health and social care

Better integration of primary and secondary health care will also help the NHS play its part in the implementation of the community care reforms set out in the *Caring for People* White Paper. This requires greater co-operation between health and social services. The first phase of this is already under way with specific grants for mental illness services and for drug and alcohol misuse services. And, as part of the transfer to local authorities of responsibility for assessing care needs and arranging service provision in April 1993, we are already seeing the development of genuinely tripartite community care plans between DHAs, FHSAs and local authority social services departments. Examples of such healthy alliances include:

- in West Dorset, the health authority and local social services department are exploring proposals for transfers of funds which will give the DHA lead responsibility for purchasing mental illness services and the local authority the lead on services for people with learning difficulties. This arrangement would prevent problems of gaps and overlaps in service provision;

- in South Birmingham, the health authority, local social services department and the voluntary organisation Turning Point have together agreed a city-wide joint contract for drug misuse counselling services, thus bypassing the possibility of disputes over divided health and social care responsibilities.

Women in the NHS

The *Women in the NHS* initiative was launched in June 1991. It aims to ensure that the issue of equal opportunities for women remains high on our managerial agenda. The NHS is the largest employer of women in Europe with over 750,000 women staff. The NHS needs to recognise their significant contribution and ensure that all women staff are afforded the opportunity to develop their full potential and contribute to the work of the service as fully as possible.

The NHS Management Executive has also become a campaign member of the *Opportunity 2000* project, a Business in the Community venture aimed at improving the quality and quantity of women's contribution to the workforce by the turn of the century. The Management Executive will be encouraging the service to sign up to the centrally-set goals and to develop their own local goals to meet local circumstances.

NHS research and development strategy

In April 1991 the first comprehensive research and development strategy for the NHS was launched. It aims to ensure that research and development becomes an integral part of health care, with clinicians, managers and other staff using the results of research in day-to-day decision making and long-term planning. The Management Executive has committed itself to raising research and development spending to 1.5 per cent of the NHS budget, to be used to reflect NHS priorities. The Central Research and Development Committee (CRDC) has subsequently been created to set these priorities for the NHS research and development programme and establish a broad framework for regions' research and development plans. The CRDC has representatives from a variety of interests including NHS and academic staff. Regions now have a major role in taking forward the management of research and development, and should be producing the first regional plans by September 1992.

"Greening" the NHS

The NHS has a central role to play in responding to public concerns about the environment. One area of particular importance is the efficient use of energy. The service has achieved a 30 per cent reduction in total energy use since 1977/8, realising cumulative savings of some £380 million. The NHS is now committed to applying additional energy efficiency measures to enable a further saving of 15 per cent to be achieved within the next five years.

Conclusion

This report shows that in the first six months of the reforms the NHS has established a firm base from which to move forward. Implementing the *Patient's Charter* will be an important part of this, as the Charter builds on the NHS reforms and aims to improve the service by making it even more responsive to patients' needs and views. Fundamental to the Charter is the belief that patients should know what they can expect from the NHS and that staff who provide services should be clear what is expected of them. That is why the Charter sets out the rights patients have and the standards of care they can expect to receive from the NHS across the country.

Ensuring that the NHS makes an effective contribution to the health strategy to be developed from the *Health of the Nation* Green Paper will also be a major element of the forward programme for the health service. All the efforts to improve health services need to be seen as one aspect of the drive to improve our health – as individuals, as communities, and as a nation.

NHS Management Executive
January 1992

Further copies are available from:
Health Publications Unit
No. 2 Site Manchester Road
Heywood
Lancashire OL10 2PZ

Prepared by the Department of Health and the Central Office of Information.
Printed in the UK for HMSO. O/N17858 HSSH J1453NJ. 70M. December 1991.